CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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Steven L. Beshear
Governor

Janie Miller
Secretary

Elizabeth A. Johnson
Commissioner

March 31, 2009

Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

Dear Ms. Justis:

Kentucky Title XIX State Plan Transmittal No. 09-002,
Minor Inpatient Hospital Payment Revisions

Enclosed is a copy of the Kentucky Title XIX Transmittal Number 09-002. This plan amendment is a revision of the Inpatient Hospital provisions to provide for minor revisions to high volume and out of state payments, and to make other minor payment enhancements or revisions. These changes are estimated to be budget neutral. The hospital upper payment limits shown in 42 CFR Part 447 shall not be exceeded.

If additional information is needed, please contact my office at 502-564-4321.

Sincerely,

Elizabeth A. Johnson
Commissioner

EJ/RD/NW/SO/kf

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 09-002

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 5, 2009

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Title XIX, Section 1902(a)(13); 42 USC Part 447.200-299

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 - None
b. FFY 2010 - None

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, pages 5, 8, 9, 14 and 15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same

10. SUBJECT OF AMENDMENT:
This inpatient hospital related plan amendment provides for minor revisions for the methodology for high volume adjustments, payments for out of state hospitals, and other minor enhancements.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Elizabeth A. Johnson

13. TYPED NAME: Elizabeth A. Johnson

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: March 31, 2009

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

Table 2 - High Volume Adjustment Eligibility Criteria

Table 2 – High Volume Adjustment Eligibility Criteria			
Kentucky Medicaid Inpatient Days		Kentucky Medicaid Inpatient Days Utilization	
Days Range	Per Diem Payment	Medicaid Utilization Range	Per Diem Payment
0 – 3,499 days	$0 per day	0.0% - 13.2%	$0.00 per day
3,500 – 4,499 days	$22.50 per day	13.3% - 16.1%	$22.50 per day
4,500 –**5999** days	$45.00 per day	16.2% +	
6,000 –7,399 days	$80.00 per day	16.2% +	
7,400 – 10,999 days	$118.15 per day	27.3% +	
11,000 – 19,999 days	$163.49 per day		
20,000 and above days	$325.00 per day		

f. The department shall use base year claims data referenced in subsection (8) of this section to determine if a hospital qualifies for a high volume per diem add-on payment.

g. The department shall only change a hospital's classification regarding a high volume add-on payment or per diem amount during a rebasing year.

h. 1) The department shall not make a high volume per diem payment for a level I neonatal care, level II neonatal center or level III neonatal center claim.

2) A level I neonatal care, level II neonatal center or level III neonatal center claim shall be included in a hospital's high volume adjustment eligibility criteria calculation established in paragraph (e) – Table 2 – of this subsection.

13. a. The department shall make an additional cost outlier payment for an approved discharge meeting the Medicaid criteria for a cost outlier for each diagnostic category.

b. A cost outlier shall be subject to QIO review and approval.

c. A discharge shall qualify for an additional cost outlier payment if its estimated cost exceeds the DRG's outlier threshold.

d. 1) The department shall calculate the estimated cost of a discharge, for purposes of comparing the discharge cost to the outlier threshold, by multiplying the sum of the hospital specific Medicare operating and capital-related cost-to-charge ratios by the Medicaid allowed charges.

2) A Medicare operating or capital-related cost-to-charge ratio shall be extracted from the CMS IPPS Pricer Program.

e. 1) The department shall calculate an outlier threshold as the sum of a hospital's DRG base payment or transfer payment and the fixed loss cost threshold.

2) The fixed loss cost threshold shall equal $29,000.

f. A cost outlier payment shall equal eighty (80) percent of the amount by which estimated costs exceed a discharge's outlier threshold.

14. The department shall calculate a Kentucky Medicaid-specific DRG relative weight by:

i. Calculating, for the purpose of a transfer payment, Kentucky Medicaid geometric mean length of stay for each DRG based on the base year claims data used to calculate DRG relative weights.

j. Employing enhanced neonatal care relative weights;

k. Applying an adjustment factor to relative weights not referenced in paragraph (j) of this subsection to offset the level I, II and III neonatal care relative weight increase resulting from the use of enhanced neonatal care relative weights; and

l. Excluding high intensity level II neonatal center claims and low intensity level III neonatal center claims from the neonatal care relative weight calculations.

15. The department shall:

a. Separately reimburse for a mother's stay and a newborn's stay based on the diagnostic category assigned to the mother's stay and to the newborn's stay;

b. Establish a unique set of diagnostic categories and relative weights for an in-state acute care hospital identified by the department as qualifying as a level I, II or III neonatal center as follows:

1) The department shall exclude high intensity level II neonatal center claims and low intensity level III neonatal center claims from the neonatal center relative weight calcu-lations;

2) The department shall reassign a claim that would have been assigned to a Medicare DRG 385-390 to a Kentucky-specific:

a) DRG 675-680 for an in-state acute care hospital with a level II neonatal center; and

b) DRG 685-690 for an in-state non-state, non-teaching acute care hospital with a level III neonatal center;

3) The department shall assign a DRG 385-390 for a neonatal claim from a hospital which does not operate a level II or III neonatal center; and

4) a) The department shall compute a separate relative weight for a level II or III neonatal intensity care unit (NICU) neonatal DRG;

b) The department shall use base year claims from level II neonatal centers, excluding claims from any high intensity level II neonatal center, to calculate relative weights for DRGs 675-680; and

c) The department shall use base year claims from level III neonatal centers to calculate relative weights for DRGs 685-690.

16. The department shall:

a. Expend in aggregate by category (level I neonatal care, level II or III neonatal center care) and not by individual facilities:

1) A total expenditure for level I neonatal care projected to equal 100% of Medicaid allowable cost for the universal rate year;

2) A total expenditure for level II neonatal center care projected to equal 100% of Medicaid allowable cost for the universal rate year; or

3) A total expenditure for level III neonatal center care projected to equal 100% of Medicaid allowable cost for the universal rate year;

b. Adjust neonatal care DRG relative weights to result in:

1) Total expenditures for level I neonatal care projected to equal 100% of Medicaid allowable cost for the universal rate year;

2.) Total expenditures for level II neonatal center care projected to equal 100% of Medicaid allowable cost for the universal rate year; or

3) Total expenditures for level III neonatal center care projected to equal 100% of Medicaid allowable cost for the universal rate year; and

(c) Not cost settle reimbursement referenced in this subsection.

17. The department shall reimburse an individual:

a. Level I neonatal center for level I neonatal care at the average cost per DRG of all level I neonatal centers;

b. Level II neonatal center for level II neonatal care at the average cost per DRG of all level II neonatal centers; or

c. Level III neonatal center for level III neonatal care at the average cost per DRG of all level III neonatal centers.

18. If a patient is transferred to or from another hospital, the department shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary.

a. For a service reimbursed on a prospective discharge basis, the department shall calculate the transfer payment amount based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus one (1) day, up to 100 percent of the allowable per discharge reimbursement amount.

1) The department shall calculate an average daily rate by dividing the DRG base payment by the statewide Medicaid geometric mean length-of-stay for a patient's DRG classification.

2) If a hospital qualifies for a high volume per diem add-on payment in accordance with Section 2(12) of this administrative regulation, the department shall pay the hospital the applicable per diem add-on for the DRG average length-of-stay.

3) Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a high volume per diem add-on amount and a cost outlier payment amount.

b. For a hospital receiving a transferred patient, the department shall reimburse the DRG base payment, and, if applicable, a high volume per diem add-on amount and a cost outlier payment amount.

19. The department shall treat a transfer from an acute care hospital to a qualifying postacute care facility for selected DRGs in accordance with paragraph (b) of this subsection as a postacute care transfer.

a. The following shall qualify as a postacute care setting:

1) A psychiatric, rehabilitation, children's, long-term, or cancer hospital;
2) A skilled nursing facility; or
3) A home health agency.

b. A DRG eligible for a postacute care transfer payment shall be in accordance with 42 U.S.C. 1395ww(d)(4)(C)(i).

Indexing for Inflation.

1. After an allowable Medicaid cost has been trended to the beginning of a universal rate year, an indexing factor shall be applied to project inflationary cost in the universal rate year.

2. The department shall use the inflation factor prepared by GII as the indexing factor for the universal rate year.

Readmission.

1. An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and reviewed by the QIO.

2. Reimbursement for a readmission with the same diagnosis shall be included in an initial admission payment and shall not be billed separately.

Reimbursement for Out-of-state Hospitals.

1. The department shall reimburse an acute care out-of-state hospital, except for a children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget whose boundaries overlap Kentucky and a bordering state and except for Vanderbilt Medical Center, for inpatient care:

   a. On a fully-prospective per discharge basis based on the patient's diagnostic category; and

   b. An all-inclusive rate.

2. The all-inclusive rate referenced in subsection 1(b) of this section shall:

   a. Equal the facility-specific Medicare base rate multiplied by the Kentucky-specific DRG relative weights, except that the DRG relative weights shall exclude any adjustment for in-state hospitals pursuant to 2006 Ky. Acts ch. 252;

   b. Exclude:

      1) Medicare indirect medical education cost or reimbursement;

      2) High volume per diem add-on reimbursement;

      3) Disproportionate share hospital distributions; and

      4) Any adjustment mandated for in-state hospitals pursuant to the 2006 State Budget; and

   c. Include a cost outlier payment if the associated discharge meets the cost outlier criteria;

      1) The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim;

      2) The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges;

3) The department shall use the Medicare operating and capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year; and

4) The department shall reimburse for inpatient care provided by Vanderbilt Medical Center at the Medicare operating and capital-related cost-to-charge ratio, extracted from the CMS IPPS Pricer Program in effect at the time the care was provided, multiplied by eighty-five (85) percent. For example, if care was provided on September 13, 2008, the cost-to-charge ratio used shall be the cost-to-charge ratio extracted from the CMS IPPS Pricer Program in effect on September 13, 2008.

5_ The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.

3. The department shall reimburse for inpatient acute care provided by an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state, an all-inclusive rate equal to the average all-inclusive base rate paid to in-state children's hospitals.

4. An out-of-state provider shall not be eligible to receive high volume per diem add-on payments, indirect medical education reimbursement or disproportionate share hospital payments.

5. The department shall make a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG. A cost outlier shall be subject to Quality Improvement Organization review and approval.

   a. The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim.

   b. The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges.

   c. The department shall use the Medicare operating and capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year.

   d. The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.

Supplemental Payments.

1. In addition to a payment based on a rate developed under Section 2 of this administrative regulation, the department shall make quarterly supplemental payments to:

   a. A hospital that qualifies as a nonstate pediatric teaching hospital in an amount:

      1) Equal to the sum of the hospital's Medicaid shortfall for Medicaid recipients under the age of eighteen (18) plus an additional $250,000 ($1,000,000 annually); and

      2) Prospectively determined by the department with an end of the year settlement based on actual patient days of Medicaid recipients under the age of eighteen (18);

   b. A hospital that qualifies as a pediatric teaching hospital and additionally meets the criteria of a Type III hospital in an amount: